

**INSIGHT YOGA THERAPY  
CLIENT HISTORY FORM**

Today's date: \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Ht. \_\_\_\_\_ Wt. \_\_\_\_\_

Address \_\_\_\_\_

Phone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

Current Occupation \_\_\_\_\_

1. Please list the type and approximate date(s) of any other body work modalities you have received (i.e. massage, shiatsu, acupuncture):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. Current exercise program: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. Experience in yoga and/or meditation: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

4. Briefly outline your personal support system (i.e., family, friends, health care providers, groups):

\_\_\_\_\_

\_\_\_\_\_

5. What do you hope to receive from Phoenix Rising Yoga Therapy? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

6. Is there anything else you'd like me to know before we start our work? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

7. How did you hear about Phoenix Rising Yoga Therapy? \_\_\_\_\_

\_\_\_\_\_

8. How did you hear about my practice in particular? \_\_\_\_\_

\_\_\_\_\_

**NOTE: The information requested on the following two pages, if you choose to provide it, will help me to work more effectively with you.**

Please fill in the following section for any condition for which you have been treated in the past two years .

Health Care Provider	Dates of Treatment (approx.)	Condition
----------------------	------------------------------	-----------

Allopathic Physician \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Psychotherapist \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Chiropractor \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Psychiatrist \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Homeopathic or  
Naturopathic Physician \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other (please list) \_\_\_\_\_  
\_\_\_\_\_

9. Please list below any prescription or non-prescription medication you're taking:

---

---

10. Please list any history of surgeries, major illness, chronic conditions, accidents, injuries, or anything that might be relevant to doing Phoenix Rising Yoga Therapy which were not listed on the previous page:

---

Date \_\_\_\_\_

---

Date \_\_\_\_\_

---

Date \_\_\_\_\_

11. Please check any condition which applies to you:

- \_\_\_\_\_ Addiction Recovery: Length of time (days, months, years) in recovery: \_\_\_\_\_
- \_\_\_\_\_ AIDS
- \_\_\_\_\_ Arthritis
- \_\_\_\_\_ Asthma
- \_\_\_\_\_ Bulging or herniated disc
- \_\_\_\_\_ Chronic Fatigue Syndrome
- \_\_\_\_\_ Contact lenses (check only if you are wearing them now)
- \_\_\_\_\_ Degenerative disc disease
- \_\_\_\_\_ Depression
- \_\_\_\_\_ Eating disorder
- \_\_\_\_\_ Emphysema or other breathing problem
- \_\_\_\_\_ Fibromyalgia
- \_\_\_\_\_ Fatigue
- \_\_\_\_\_ Fused vertebrae
- \_\_\_\_\_ Heart condition
- \_\_\_\_\_ Hernia
- \_\_\_\_\_ High blood pressure: Do you take medication? \_\_\_\_\_
- \_\_\_\_\_ Hepatitis: Type \_\_\_\_\_
- \_\_\_\_\_ History of physical, sexual, and/or emotional abuse
- \_\_\_\_\_ Low blood pressure
- \_\_\_\_\_ Menopause
- \_\_\_\_\_ Multiple sclerosis
- \_\_\_\_\_ Osteoporosis
- \_\_\_\_\_ Pregnancy: How many months? \_\_\_\_\_

